The CAMS Approach to Suicide Risk

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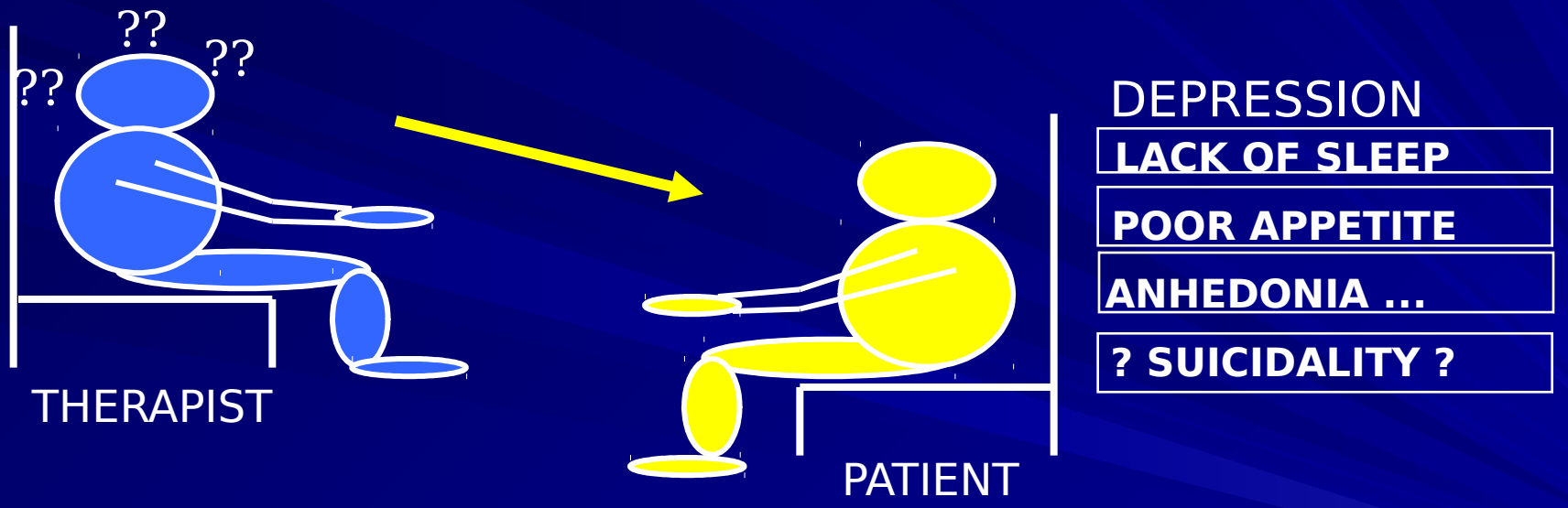
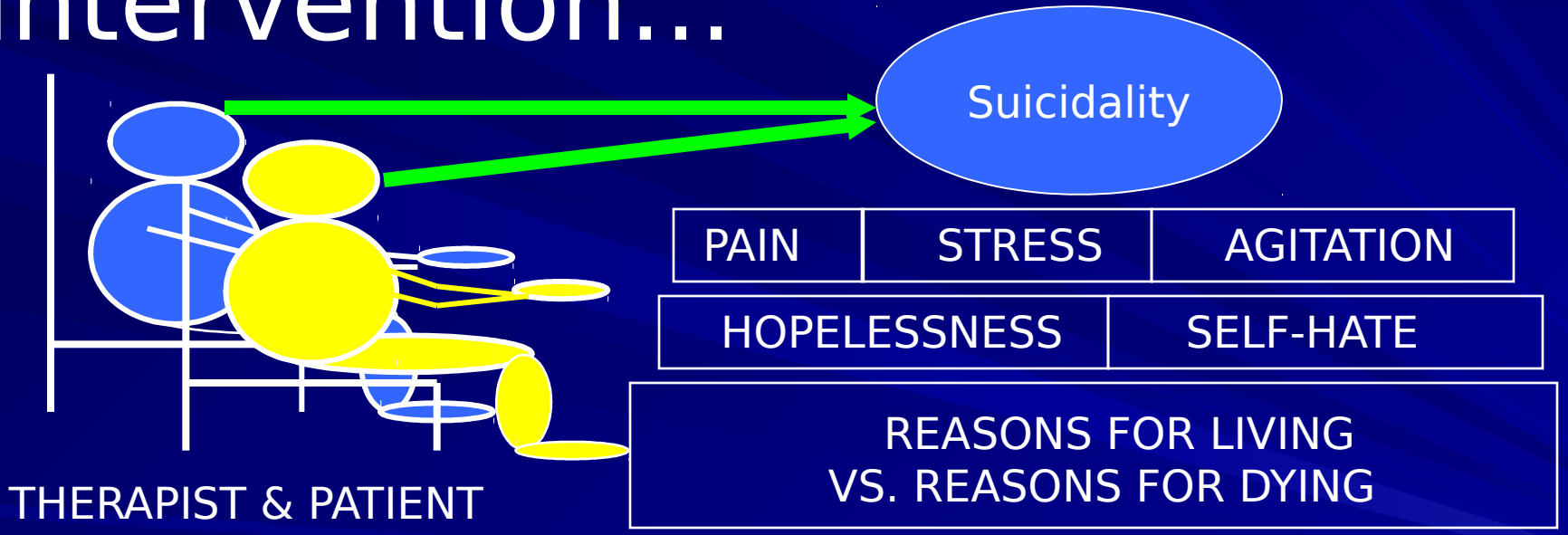
Critique of Current Approach to Suicide Risk: THE REDUCTIONISTIC MODEL (Suicide = Symptom of Psychopathology)



Traditional treatment = inpatient hospitalization, treating the psychiatric disorder, and using no suicide contracts...

CAMS targets ***Suicide*** as the primary focus of assessment and problem-focused intervention…



The Suicide Status Form (SSF) is used to guide assessment and

Adherence to CAMS

CAMS is a therapeutic framework, used until suicidality resolves. Adherence to CAMS requires thorough suicide risk assessment and problem-focused interventions that are designed to directly and indirectly decrease suicide risk (Jobes, Comtois, Brenner, & Gutierrez, 2011).

Therapeutic Philosophy

1. Collaboration
   - Empathy with the suicidal wish
   - Clarify the CAMS agenda
   - All assessments/interventions are interactive
2. Suicide-focus ultimately guides all therapeutic activity

Clinical Framework

1. Assess index and on-going suicide risk using the SSF every clinical contact
2. All SSF-guided interventions are meant to eliminate direct or indirect causes of suicidal risk (so called “drivers” of suicide risk).
   - A suicide-specific treatment plan with Crisis Response/Safety Plan
   - Reduce access to lethal means
   - Insure treatment attendance

Overview to CAMS Assessment and Care

CAMS is a suicide-specific therapeutic framework, emphasizing five core components of collaborative clinical care (over 10-12 sessions/3 months).

- Component I. Collaborative Assessment of Suicidal Risk
- Component II. Collaborative Treatment Planning
  - Attend treatment reliably as scheduled over the next three months
  - Reduce access to lethal means
  - Develop and use a Coping Card as part of Crisis Response Plan
  - Create interpersonal supports
- Component III. Collaborative Deconstruction of Suicidogenic Problems
  - Relationship issues (especially family)
  - Vocational issues (what do they do?)
  - Self-related issues (self-worth/self-esteem)
  - Pain and suffering—general and specific
- Component IV. Collaborative Problem-Focused Interventions
- Component V. Collaborative Development of Reasons for Living

There is correlational support for the effectiveness of CAMS/SSF in real-world clinical settings (Arkov et al., 2008; Jobes et al., 1997; 2009). In US Air Force Study (n=55), use of CAMS was related to more rapid resolution of suicidal thinking and decreased ED and Primary Care visits (Jobes et al., 2005)

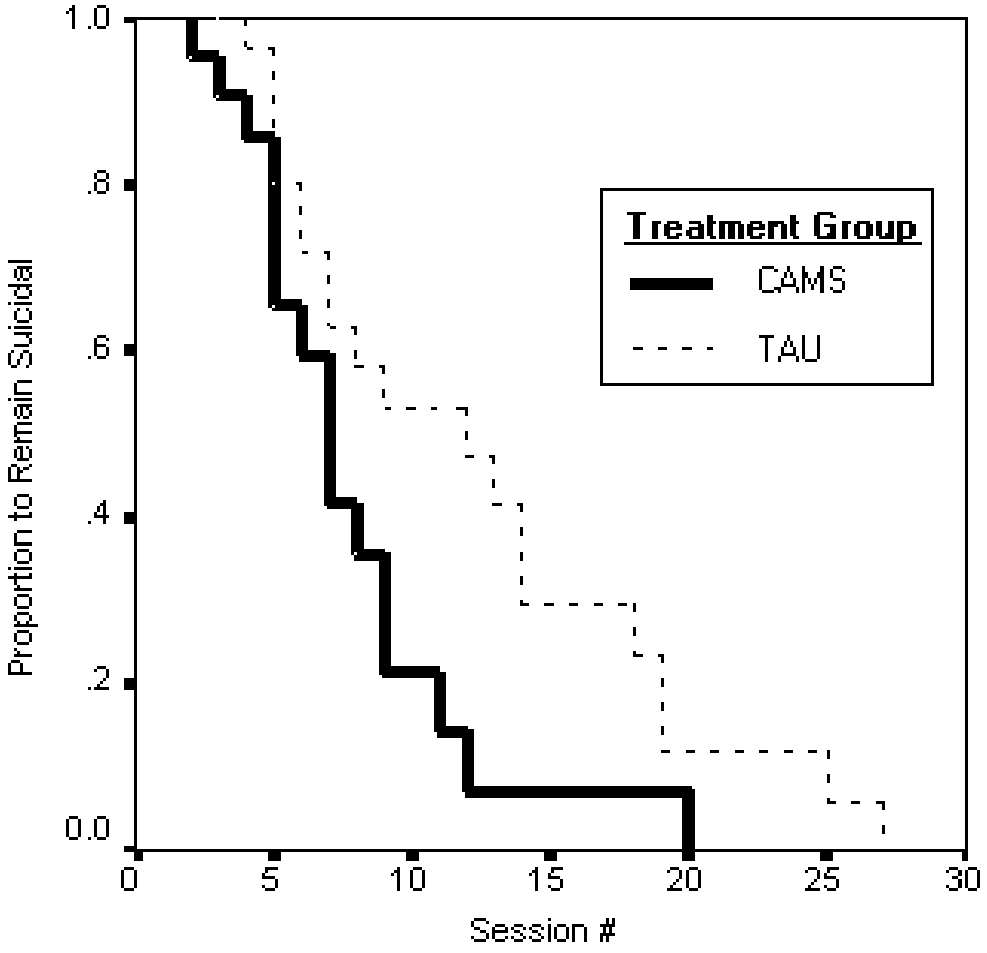
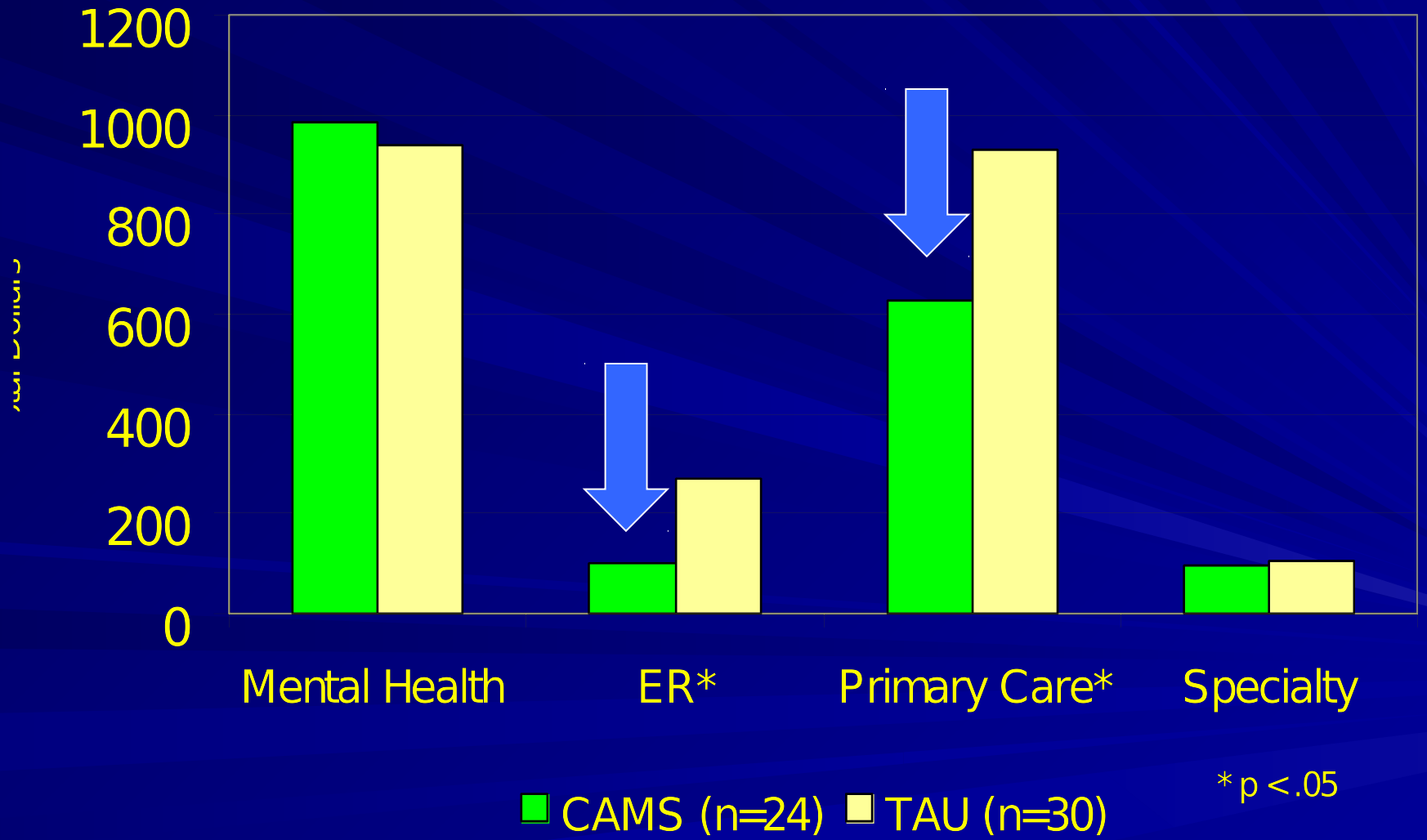


Figure 1. Estimated proportion of patients in the CAMS and TAU group to remain suicidal as a function of session number.

10th Medical Group Research: Six Month Period After the Start of Mental Health Care—Mean Health Care Costs



Treatment of Suicidal Patients with the Collaborative Assessment and Management of Suicidality: A Feasibility Randomized Clinical Trial

(Funded by the American Foundation for Suicide Prevention —AFSP)

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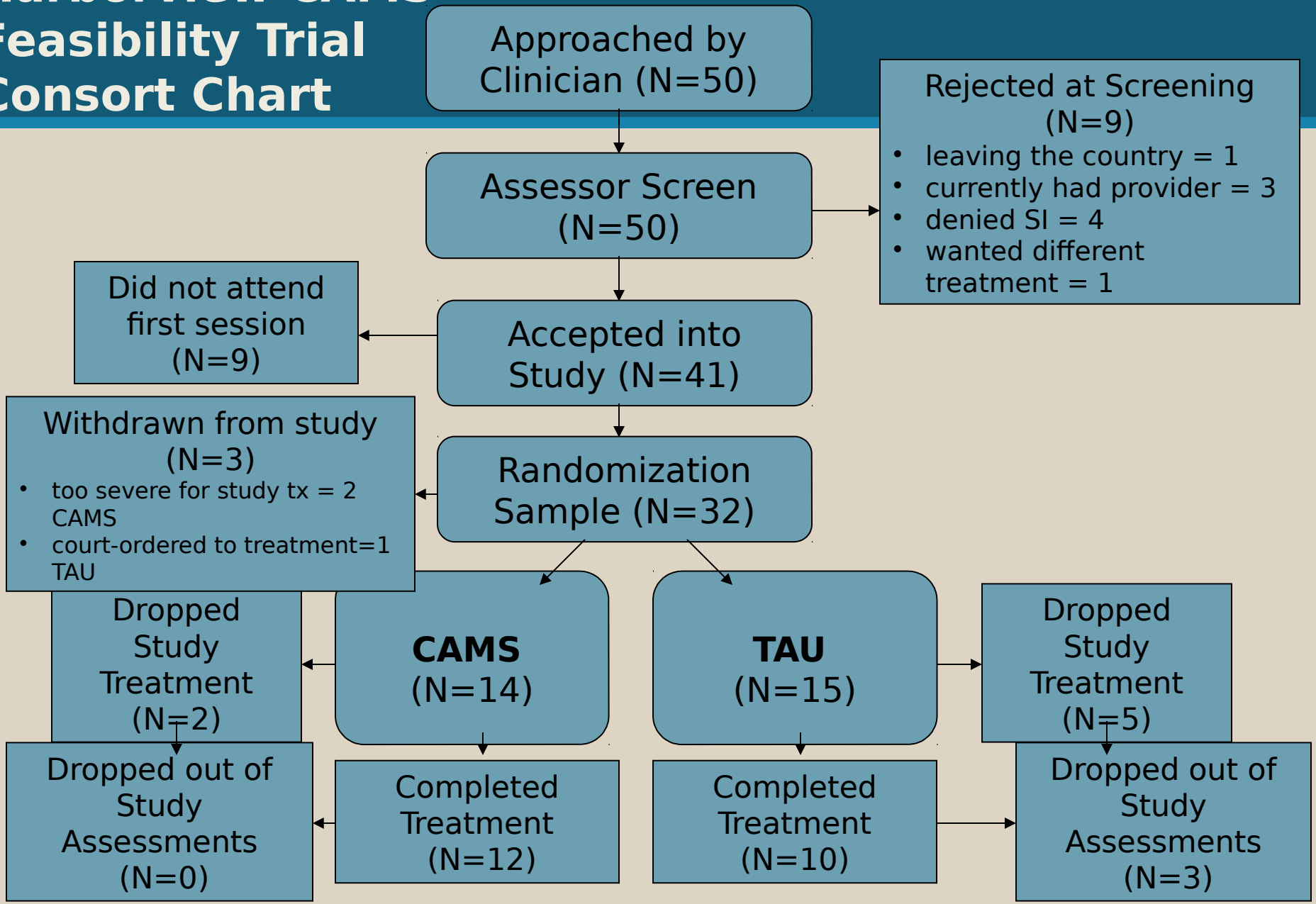
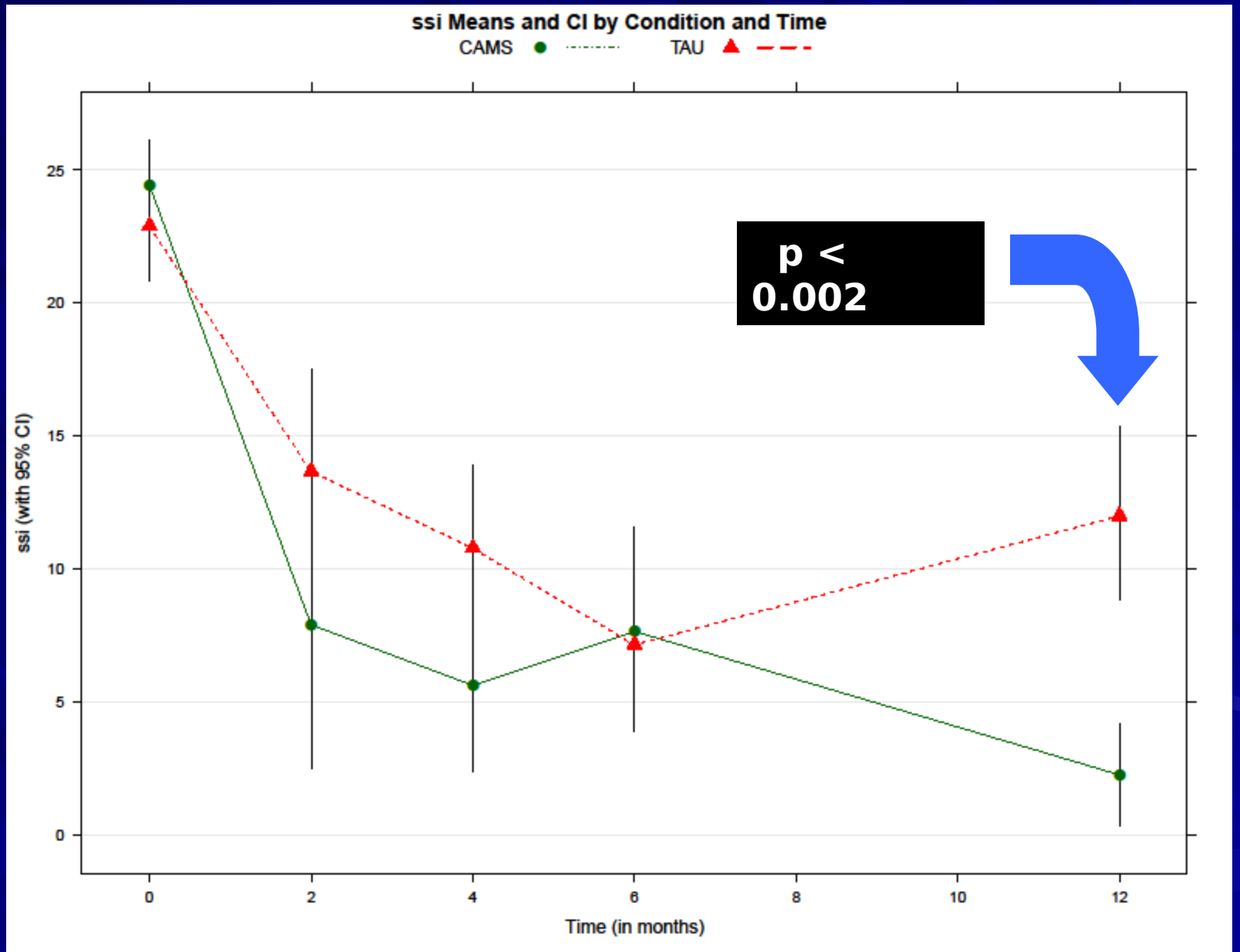
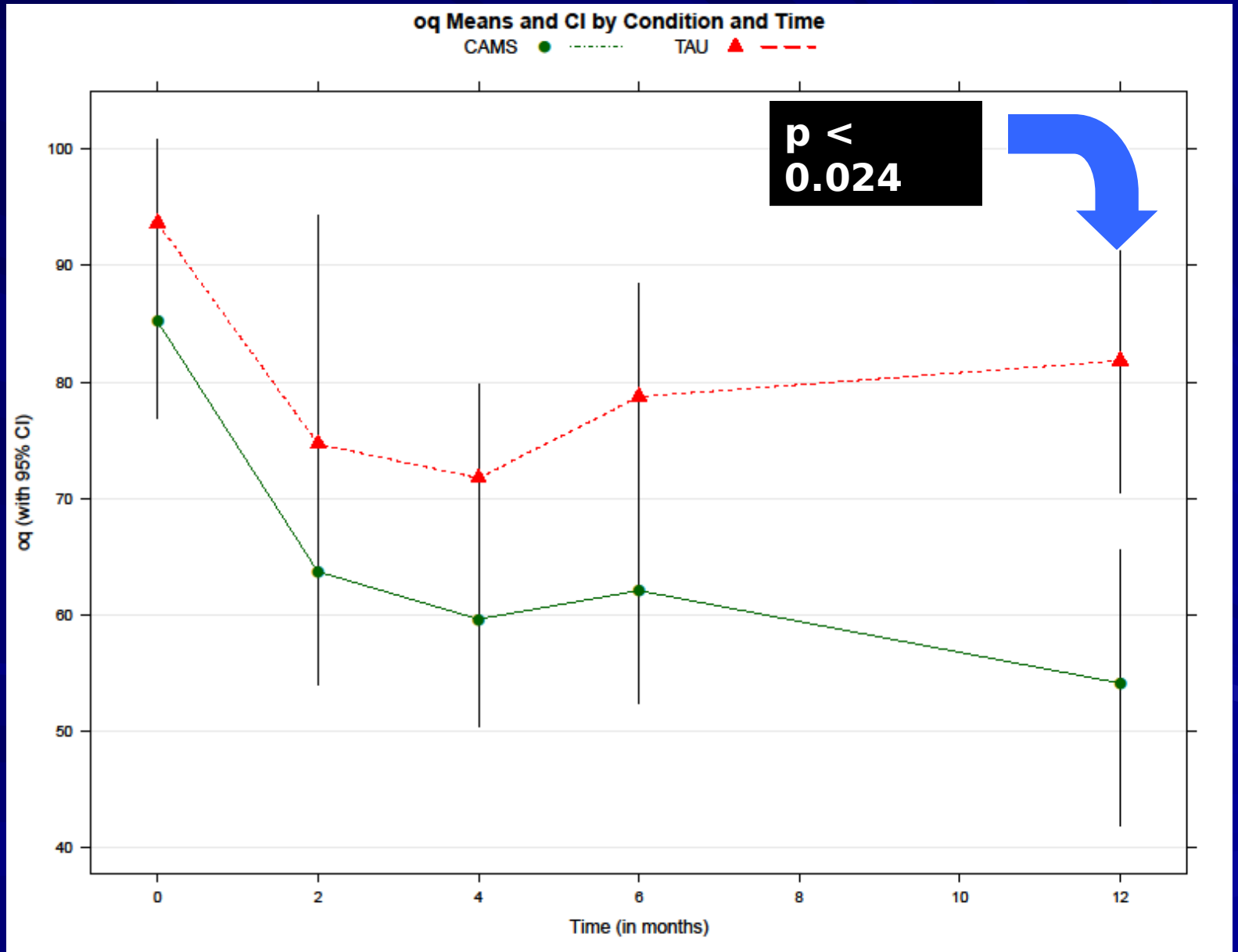
Harborview CAMS Feasibility Trial Consort Chart


Approached by Clinician (N=50)
Assessor Screen (N=50)
Rejected at Screening (N=9)
• leaving the country = 1
• currently had provider = 3
• denied SI = 4
• wanted different treatment = 1
Did not attend first session (N=9)
Accepted into Study (N=41)
Withdrawn from study (N=3)
• too severe for study tx = 2 CAMS
• court-ordered to treatment=1 TAU
Randomization Sample (N=32)
Dropped Study Treatment (N=2)
CAMS (N=14)
TAU (N=15)
Dropped Study Treatment (N=5)
Dropped out of Study Assessments (N=0)
Completed Treatment (N=12)
Completed Treatment (N=10)
Dropped out of Study Assessments (N=3)

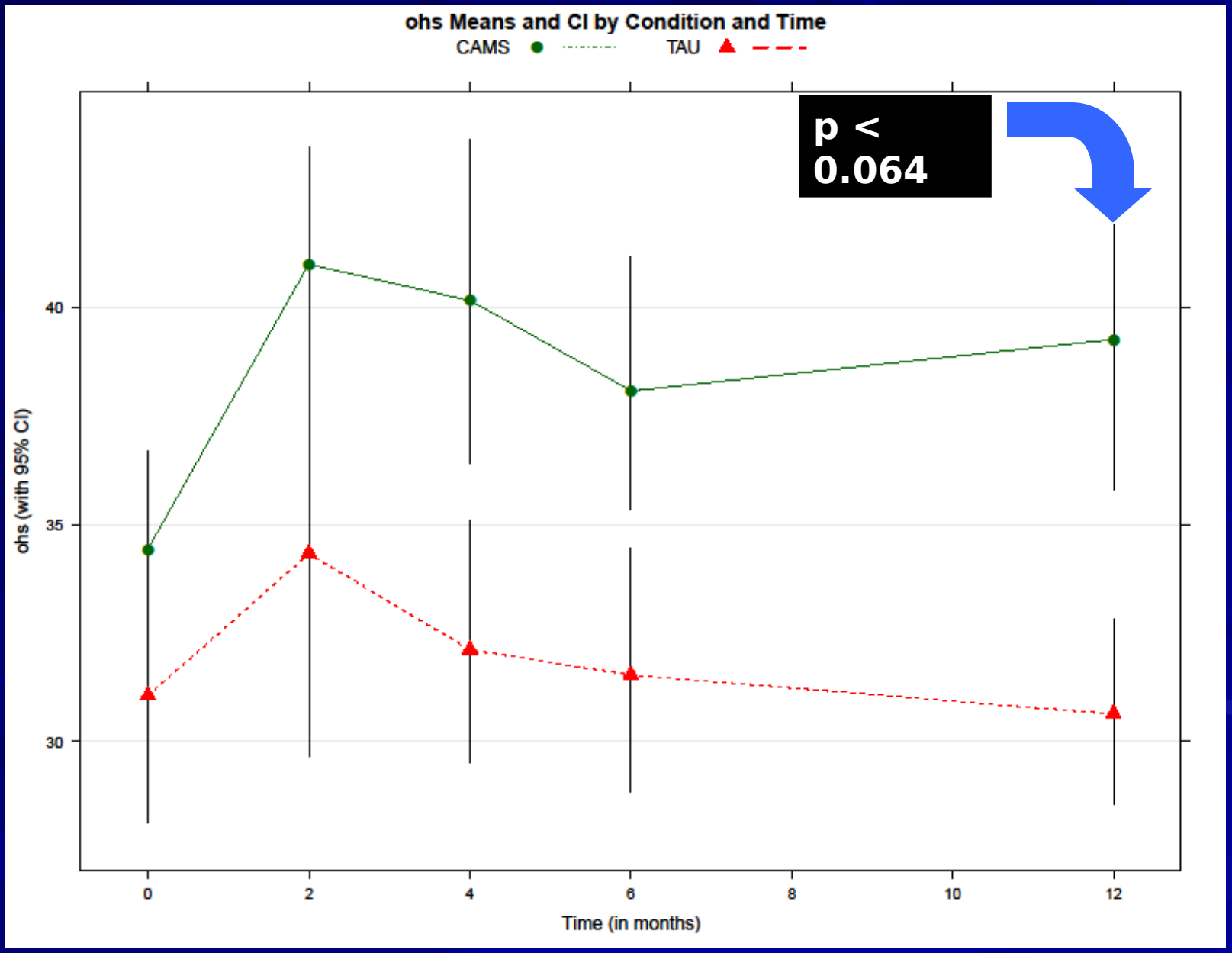
Primary Measure: Scale for Suicide Ideation



Secondary Measures: Overall Symptom Distress (OQ-45)



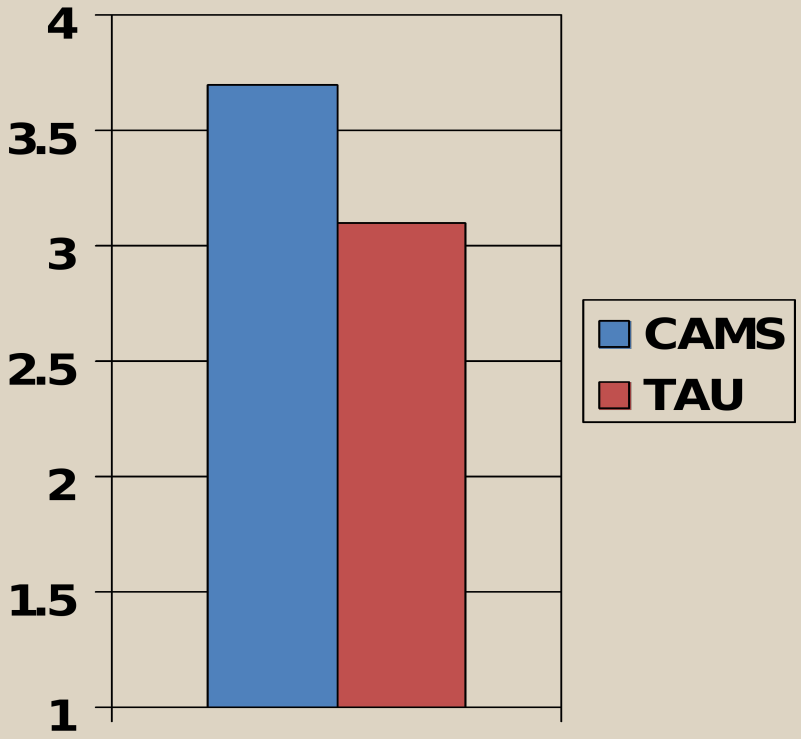
Hopelessness Scale



Client Satisfaction

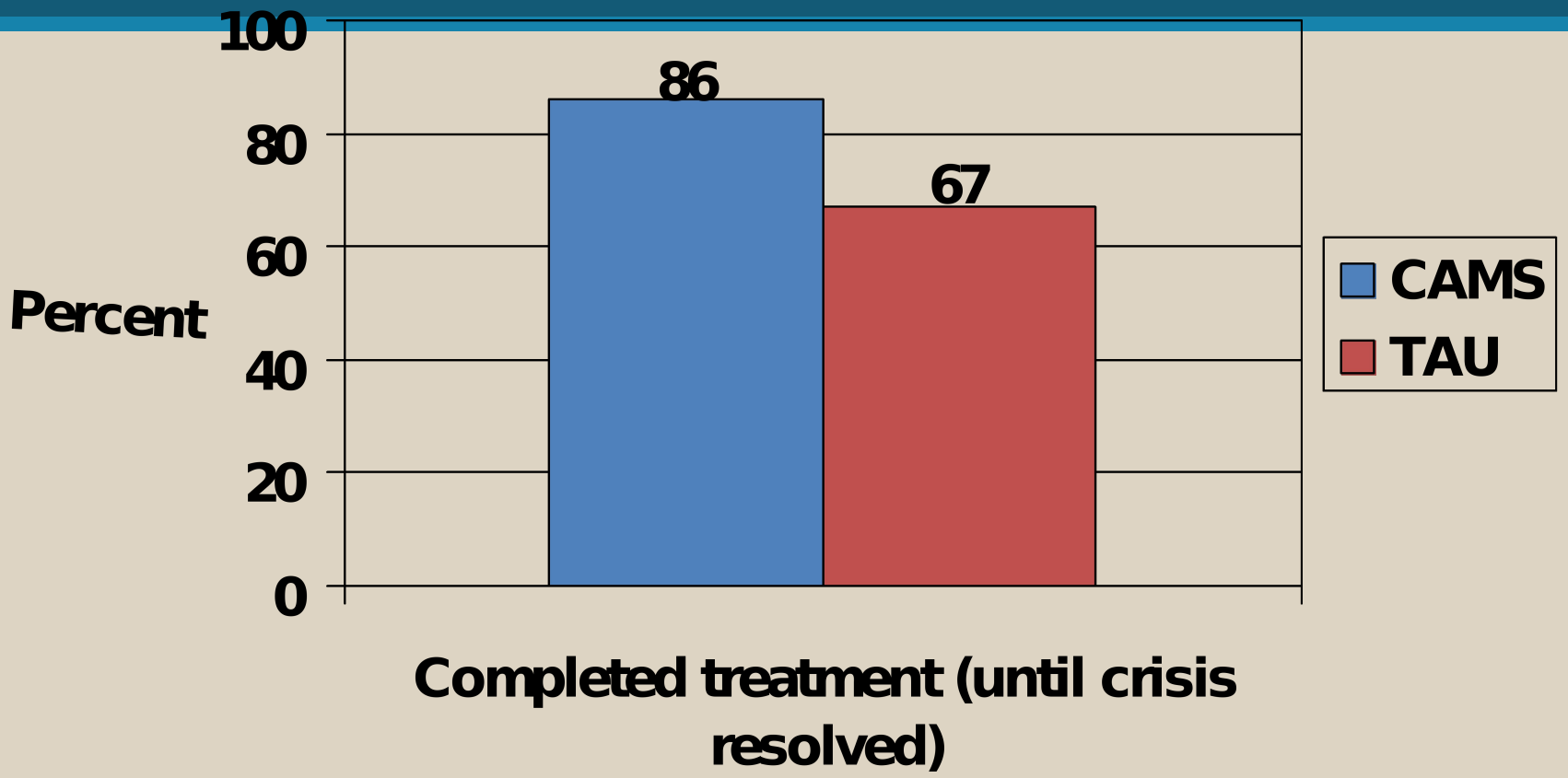
Average client satisfaction was high for both treatments (range 1-4).

Satisfaction higher for the CAMS treatment condition



t(24)=-2.76 p=.01

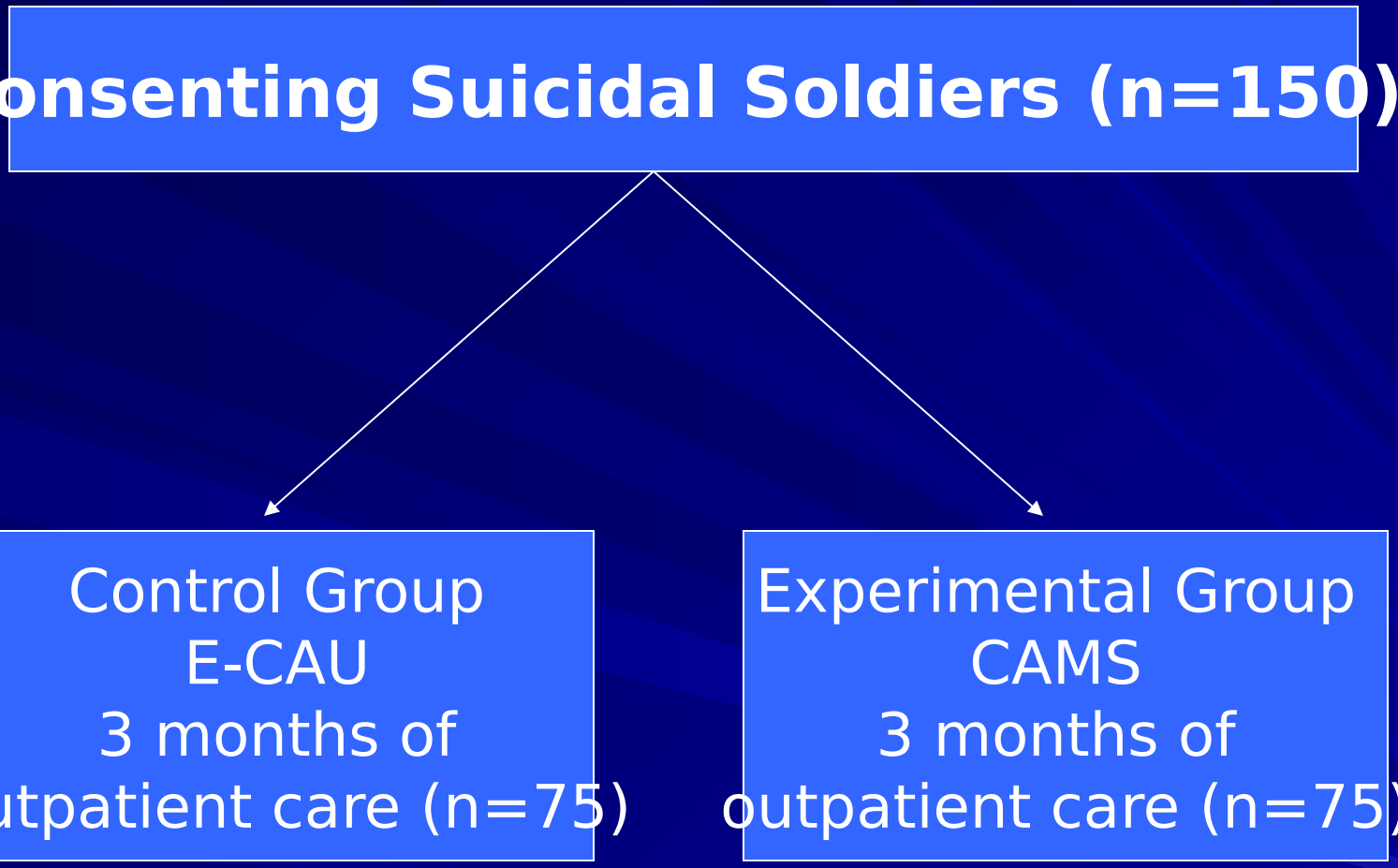
Treatment Retention



Total sessions ranged from low of 1 to high of 16 sessions:

CAMS = 2 to 16 sessions (mean = 8.5), 7% subject had < 3 sessions

CAMS RCT at Ft. Stewart, GA



ndent Variables: Suicidal Ideation/Attempts, Symptom Distress, Resiliency, Prim
Care visits, Emergency Department Visits, and Hospitalization

ures: SSI, OQ-45, SHBQ, SASIC, CDRISC, PCL-M, SF-36, NFI, THI (at 1, 3, 6, 12 mo

Various other CAMS projects…

- At Denver VAMC VISN 19 MIRECC we conducted a crucial CAMS feasibility study.
- In Copenhagen a 2-4 session version of CAMS is being studied for suicidal outpatients in two community MH clinics (n=60/site).
- Starting in 2011 a new adolescent version of CAMS will be studied in Georgia juvenile justice system.
- Charleston VAMC CAMS E-learning training research project is in progress (live CAMS training vs. web-based CAMS training).

Projects continued…

- In Newcastle (AU) an 8 session use of CAMS is being developed in a primary care model.
- CAMS training and feasibility study with Native American teens (funded by IHS) in Gallup NM is being pursued.
- Warrior Resiliency Program (WRP) at Brook Army Medical Center is funding the CUA team in process improvement project to adapt and use CAMS in the Warrior Clinic.
- We are now developing a new CAMS-focused collaboration with WRAMC and NNMC.